		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005405

Facility Name: HILLTOP CONVALESCENT CENTER

Address: 910 W. POLK (Number) CHARLESTON (City) 61920 (Zip Code)

County: COLES

Telephone Number: (217) 345-7006 **Fax #** (217) 345-6017

IDPA ID Number: 3707766700001

Date of Initial License for Current Owners: 07/01/58

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/01/99 to 07/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JERRY W. JENNINGS

(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99) IL478-2471

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	36	Skilled (SNF)	36	13,176	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,352	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	866		2,684	3,550	8
9	SNF/PED					9
10	ICF	12,236	5,480		17,716	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,102	5,480	2,684	21,266	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.80%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 07/01/58

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 2684

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 07/31/00 Fiscal Year: 07/31/00

* All facilities other than governmental must report on the accrual basis.

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	68,764	7,596	3,225	79,585		79,585	0	79,585			1
2	Food Purchase		53,636		53,636		53,636	(797)	52,839			2
3	Housekeeping	28,493	7,765		36,258		36,258	0	36,258			3
4	Laundry	16,105	8,406		24,511		24,511	0	24,511			4
5	Heat and Other Utilities			49,773	49,773		49,773	0	49,773			5
6	Maintenance	15,378	9,983	23,734	49,095		49,095	1,372	50,467			6
7	Other (specify):* UTILITY WORKE	20,947			20,947		20,947	0	20,947			7
8	TOTAL General Services	149,687	87,386	76,732	313,805		313,805	575	314,380			8
	B. Health Care and Programs											
9	Medical Director			11,400	11,400		11,400	0	11,400			9
10	Nursing and Medical Records	502,581	60,789	17,222	580,592	(46,359)	534,233	346	534,579			10
10a	Therapy	7,596	756	124,345	132,697	(124,345)	8,352	0	8,352			10a
11	Activities	21,459	1,265		22,724		22,724	0	22,724			11
12	Social Services			1,768	1,768		1,768	0	1,768			12
13	Nurse Aide Training			60	60		60	0	60			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	531,636	62,810	154,795	749,241	(170,704)	578,537	346	578,883			16
	C. General Administration											
17	Administrative	51,705		8,604	60,309	1,410	61,719	27,777	89,496			17
18	Directors Fees							0				18
19	Professional Services			148,909	148,909		148,909	(142,307)	6,602			19
20	Dues, Fees, Subscriptions & Promotions			7,537	7,537		7,537	(1,703)	5,834			20
21	Clerical & General Office Expenses	20,274	4,325	5,574	30,173		30,173	12,884	43,057			21
22	Employee Benefits & Payroll Taxes			89,433	89,433		89,433	6,960	96,393			22
23	Inservice Training & Education			591	591		591	87	678			23
24	Travel and Seminar			3,991	3,991	(3,881)	110	765	875			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			45,953	45,953		45,953	204	46,157			26
27	Other (specify):*			33,586	33,586		33,586	(33,586)				27
28	TOTAL General Administration	71,979	4,325	344,178	420,482	(2,471)	418,011	(128,919)	289,092			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	753,302	154,521	575,705	1,483,528	(173,175)	1,310,353	(127,998)	1,182,355			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,654	17,654		17,654	3,187	20,841			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes			34,176	34,176		34,176	0	34,176			33
34	Rent-Facility & Grounds							2,875	2,875			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			51,830	51,830		51,830	6,062	57,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					173,175	173,175	0	173,175			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			59,292	59,292		59,292	0	59,292			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**			59,292	59,292	173,175	232,467		232,467			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	753,302	154,521	686,827	1,594,650	0	1,594,650	(121,936)	1,472,714			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,910	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(965)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,745)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,575)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,548)	27		24
25	Fund Raising, Advertising and Promotional	(1,667)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,718)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(180)	20		28
29	Other-Attach Schedule VENDING	(797)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (35,285)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(87,494)	VAR	34
35	Other- Attach Schedule SCH XIX-H COL 8	843	6	35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (86,651)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (121,936)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		124,345	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		996	10	42
43	Prescription Drugs	X		39,124	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule OXYGEN	X		5,050	10	45
46	Other-Attach Schedule MED SUPP &	X		3,660	10	46
47	TOTAL (C): (sum of lines 38-46)			$ 173,175		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS **Page 5A**

Facility Name HILLTOP CONVALESCENT CENTER
ID# 0005405
Report Period Beginning: 08/01/99
Ending: 07/31/00

Print Other Adjustments

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	0
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	0
9	Non-Straightline Depreciation	1,910	30	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	(965)	21	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	(1,745)	27	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	(16,575)	27	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	0	0	Line 19	0
21	Owner or Key-Man Insurance	0	0	Line 20	(1,847)
22	Special Legal Fees & Legal Retainers	0	0	Line 21	(965)
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	(10,548)	27	Line 23	0
25	Fund Raising, Advertising and Promotional	(1,667)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	(4,718)	27	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	(180)	20	Line 27	(33,586)
29	Non-Paid Workers	0	0	Line 28	(36,398)
30	Donated Goods	0	0	Line 29	(36,398)
31	Amortization Expense	0	0	Line 30	1,910
32				Line 31	0
33				Line 32	0
34				Line 33	0
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	1,910
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(34,488)

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 08/01/99 **Ending:** 07/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	344	0	0	0	0	0	0	0	0	0	344	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(142,453)	0	0	0	0	0	0	0	0	0	(142,453)	19
20	Fees, Subscriptions & Promotions	(1,847)	0	0	0	0	0	0	0	0	0	0	(1,847)	20
21	Clerical & General Office Expenses	(965)	0	0	0	0	0	0	0	0	0	0	(965)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(344)	0	0	0	0	0	0	0	0	0	(344)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(33,586)	0	0	0	0	0	0	0	0	0	0	(33,586)	27
28	**TOTAL General Administration**	(36,398)	(142,453)	0	0	0	0	0	0	0	0	0	(178,851)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,398)	(142,453)	0	0	0	0	0	0	0	0	0	(178,851)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	1,910	0	0	0	0	0	0	0	0	0	0	1,910	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,910	0	0	0	0	0	0	0	0	0	0	1,910	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,488)	(142,453)	0	0	0	0	0	0	0	0	0	(176,941)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: HILLTOP CONVALESCENT CENTER — # 0005405 — Report Period Beginning: 08/01/99 — Ending: 07/31/00

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
R. RAYMOND KLEIN	29.39	D'ADRIAN CONVALESCENT CENTER, INC	GODFREY	Nursing Home Mngrs,	SPRINGFIELD	MANAGEMENT
ALVCE KLEIN	38.79	JACKSONVILLE CONVALESCENT CENTER, INC	JACKSONVILLE			
DANA KLEIN	4.24	MEADOW MANOR, INC	TAYLORVILLE			
PHILIP KLEIN	4.24	MENARD CONVALESCENT CENTER, INC	PETERSBURG			
LISA K. GILDAR	4.24	SUNRISE MANOR OF VIRDEN, INC	VIRDEN			
DAVID & RAQUEL KLEIN	4.55					
JERRY & PAULA JENNINGS	4.55					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger		4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
1	V	25 MANAGEMENT FEE	$ 148,711	NURSING HOME MANAGERS, INC	29.39%	$	$ (148,711)	1	-148711	
2	V	VARIOUS SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC		54,959	54,959	2	54959	
3	V	27 ACCOUNTING		NURSING HOME MANAGERS, INC		8,358	8,358	3	8358	
4	V	24 TRAVEL	344	TO TRANSFER 21% OF HOME OFFICE TRAVEL			(344)	4	-344	
5	V	27 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		344	344	5	344	
6	V							6		
7	V							7		
8	V							8		
9	V							9		
10	V							10		
11	V							11		
12	V							12		
13	V							13		
14	Total		$ 149,055			$ 63,561	$ * $ (85,494)	14		

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.55					$ 10,072	17-7	1
2	H. RAYMOND KLIEN	OWNER	MANAGEMENT	39.39					1,433	17-7	2
3	SAM KLEIN	PRESIDENT	MANAGEMENT	0.00					1,433	17-7	3
4											4
5											5
6		Jerry Jennings, Sam Klein, and H. Raymond Klein were paid by Nursing Home Managers, Inc.,									6
7		a related organization. Total compensation of $10010 for each Sam Klein and H. Raymond Klein was									7
8		allocated among the six related nursing homes, based upon 10 hours per week for Sam Klein and									8
9		10 hours per week for H. Raymond Klein. For Jerry Jennings $70322 of compensation was									9
10		allocated among the related homes based upon 35 hours per week.									10
11											11
12											12
13								TOTAL	$ 12,938		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC
Street Address: 2653 W. LAWRENCE, SUITE B.
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4		SEE ATTACHED SCHEDULES								4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	38,074	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	34,839	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,235)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	37,411	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	34,176	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	34,072	8
1996	35,532	9
1997	38,484	10
1998	35,146	11
1999	34,533	12

LINE 2 2ND INSTALLMENT 1998 17573

1ST INSTALLMENT 1999 17266

34839

LINE 4 2ND INSTALLMENT 1999 17267

7/12 OF 34533 20144

3741

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,709 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1966	$ 5,295	1
2					2
3	TOTALS			$ 5,295	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1966		$ 253,434	$	30	$	$	$ 253,434	4
5	36			1972	240,043	2,470	30		(2,470)	240,043	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	2,877		10			2,877	9
10	LANDSCAPING			1980	1,417		5			1,417	10
11	IMPROVEMENT			1979	17,131		15			17,131	11
12	IMPROVEMENT			1981	4,330		VAR			4,330	12
13	IMPROVEMENT			1982	3,570		15			3,570	13
14	IMPROVEMENT			1983	3,583		15			3,583	14
15	IMPROVEMENT			1984	2,461		15			2,461	15
16	IMPROVEMENT			1985	14,201	789	15	470	(319)	14,201	16
17	AIR CONDITIONER			1986	1,620	84	10		(84)	1,620	17
18	CONDENSOR			1986	3,068	160	15	205	45	2,972	18
19	ROOF			1986	19,843	1,032	15	1,323	291	18,632	19
20	CUBICAL TRACKS			1987	997	32	20	50	18	700	20
21	AIR CONDITIONER			1987	1,149	36	10		(36)	1,149	21
22	AIR CONDITIONER			1988	3,145	100	10		(100)	3,145	22
23	WATER HEATER			1988	982	31	15	65	34	791	23
24	WATER HEATER			1989	2,194	70	15	146	76	1,557	24
25	AIR CONDITIONING			1991	1,959	62	10	196	134	1,797	25
26	SIDEWALK			1991	3,120	99	20	156	57	1,508	26
27	WIRING			1992	1,384	44	20	69	25	610	27
28	AIR CONDITIONING			1992	1,474	47	10	147	100	1,188	28
29	DOOR ALARM, FURNACE, IMPROVEMENT			1993	6,664	211	15	444	233	3,330	29
30	LANDSCAPING			1993	2,824	188	10	282	94	2,115	30
31	BLACKTOP-PER 1991 AUDIT			1990	2,186		15	146	146	1,022	31
32	AIR CONDITIONING			1994	1,613	41	10	161	120	993	32
33	LIGHTING			1995	2,729	70	10	273	203	1,501	33
34	AIR CONDITIONING			1996	1,112	28	8	139	111	568	34
35	EXHAUST FAN, FLOORING, WATER HEATERS			1996	5,048	129	15	337	208	1,516	35
36	TOTAL (lines 4 thru 35)				$ 606158	$ 5,723		$ 4,609	$ (1,114)	$ 589,761	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING-WALLS			1996	1,080	28	30	36	8	144	9
10	WATER HEATER			1996	1,611	41	15	107	66	393	10
11	REMODELING-WALLS			1997	10,714	275	30	357	82	1,160	11
12	AIR CONDITIONERS			1999	3,185	82	10	319	237	506	12
13	ROOF			1999	68,332	1,752	20	3,417	1,665	3,986	13
14	FURNACE			2000	1,273	27	15	71	44	71	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 86,195	$ 2,205		$ 4,307	$ 2,102	$ 6,260	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 126,243	$ 8,389	$ 10,349	$ 1,960		$ 64,105	37
38	Current Year Purchases	8,487	1,337	299	(1,038)		299	38
39	Fully Depreciated Assets	147,467					147,467	39
40	ASSETS NO LONGER IN SERVICE	(58,078)					(58,078)	40
41	TOTALS	$ 224,119	$ 9,726	$ 10,648	$ 922		$ 153,793	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42		N/A		$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 921,767	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 17,654	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 19,564	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 1,910	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 749,814	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		60		60
9	TOTALS	$	$ 60	$	$ 60
10	SUM OF line 9, col. 1 and 2 (e)	$ 60			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-5	hrs	$	1,133	$ 48,200	$	1,133	$ 48,200	1
2	Licensed Speech and Language Development Therapist	39-5	hrs		240	6,239		240	6,239	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-5	hrs		1,535	69,906		1,535	69,906	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-5	# of prescrpts				39,124		39,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): O2, IV, MC Supp, Lab	39-5					9,706		9,706	13
14	TOTAL			$	2,908	$ 124,345	$ 48,830	2,908	$ 173,175	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 07/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 80,424	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	226,939		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,833		6
7	Other Prepaid Expenses	90,427		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 416,623	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	77,374		12
13	Land	5,295		13
14	Buildings, at Historical Cost	690,167		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	280,628		16
17	Accumulated Depreciation (book methods)	(827,750)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 225,714	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 642,337	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 58,232	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,738		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,318		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,411		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,718		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 138,417	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 138,417	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 503,920	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 642,337	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 609,110	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 609,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	315,560	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(420,750)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (105,190)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 503,920	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,858,890	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,858,890	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,912	6
7	Oxygen	5,050	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 22,962	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	986	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 986	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,828	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,828	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending 797, Admit 480, Copies 285, Old checks 190	1,752	28
28a	Gain on Investment 20626, Bad Debt Rec. 156, W/A 10	20,792	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,544	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,910,210	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 313,805	31
32	Health Care	749,241	32
33	General Administration	420,482	33
	B. Capital Expense		
34	Ownership	51,830	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	59,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,594,650	40
41	**Income before Income Taxes (line 30 minus line 40)****	315,560	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 315,560	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,400	1,408	$ 25,387	$ 18.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,159	8,802	134,597	15.29	3
4	Licensed Practical Nurses	7,678	8,001	85,588	10.70	4
5	Nurse Aides & Orderlies	29,233	29,678	257,009	8.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	804	809	7,596	9.39	8
9	Activity Director	1,249	1,273	9,744	7.66	9
10	Activity Assistants	2,134	2,173	11,715	5.39	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,723	1,809	17,640	9.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,051	8,318	51,124	6.15	15
16	Dishwashers					16
17	Maintenance Workers	2,327	2,413	15,378	6.37	17
18	Housekeepers	5,072	5,218	28,493	5.46	18
19	Laundry	2,580	2,825	16,105	5.70	19
20	Administrator	2,000	2,080	51,705	24.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,097	2,177	20,274	9.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	3,911	3,971	20,947	5.28	33
34	TOTAL (lines 1 - 33)	78,417	80,953	$ 753,302 *	$ 9.31	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 3,225	1-3	35
36	Medical Director	120	11,400	9-3	36
37	Medical Records Consultant	8	320	10-3	37
38	Nurse Consultant	406	15,373	10-3	38
39	Pharmacist Consultant	48	600	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	33	1,768	12-3	45
46	Other(specify)				46
47	ADMINISTRATIVE CONSULTAN	333	8,604	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,064	$ 41,290		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	50	929	10-3	52
53	TOTAL (lines 50 - 52)	50	$ 929		53

Print Preview

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Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ARACELI HENSON	ADMINISTRATOR		$ 51,705
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,705

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 8,604
TOTAL (agree to Schedule V, line 17, col. 3)	$ 8,604
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT FEE	$ 148,711
CSC	CORP. REPRESENTATION	198
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 148,909

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,619
Unemployment Compensation Insurance	6,498
FICA Taxes	56,124
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE CAFETERIA PLAN	10,717
EMPLOYEE LIFE INSURANCE	1,419
HOLIDAY PARTIES	411
GIFT CERTIFICATES	645
NURSING HOME MANAGERS ALLOCATION	6,960
TOTAL (agree to Schedule V, line 22, col.8)	$ 96,393

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HOLIDAY PARTIES	22	$ 411
GIFT CERTIFICATES	22	645
TOTAL		$ 1,056

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,549
Health Care Worker Background Check	888
(Indicate # of checks performed 74)	
PUBLIC RELATIONS	1,667
YELLOW PAGES	180
HCFA LAB FEE	150
FRANCHISE FEE	103
NURSING HOME MANAGERS ALLOCATI	144
Less: Public Relations Expense	(1,667)
Non-allowable advertising	( )
Yellow page advertising	(180)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,834

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISC MILEAGE REIMBURSEMENT	110
Seminar Expense	
NURSING HOME MANAGERS ALLOCATI	1,109
LESS 31% OF NHM TRAVEL	
TRANSFERRED TO LINE 17	(344)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 875

**See instructions.

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT	9/90	$ 1,925	3 YR	$	$	$	$	$	$	$	$	$
2	DECORATION	7/93	1,884	3 YR									
3	PAINT & WALLCOVI	7/94	3,986	3 YR	664								
4	PAINT & WALLPAPE	7/96	3,825	3 YR	1,275	1,275	637						
5	PAINT & WALLPAPE	3/97	5,058	3 YR	843	1,686	1,686	843					
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 16,678		$ 2,782	$ 2,961	$ 2,323	$ 843	$	$	$	$	$

Print Preview

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/99 Ending: 07/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ $ 69 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ $ 59292
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

SCHEDULE V PAGES 3 & 4

OTHER LINE 27 COLUMN 3		
BAD DEBT	$	10548
SALES TAX		1745
FINES & PENALTIES		16575
ILLINOIS RT TAX		4718
	$	33586

DETAIL OF RECLASSIFICATIONS	COLUMN 5		LINE #
RECLASS FROM:			
OXYGEN	$	-5050	10
MEDICARE DRUGS		-39124	10
MEDICARE SUPPLIES		-530	10
MEDICARE LAB FEES		-996	10
MEDICARE IV'S		-3130	10
PHYSICAL THERAPY		-69906	10A
SPEECH THERAPY		-6239	10A
OCCUPATIONAL THERAPY		-48200	10A
RECLASS TO: ANCILLARY	$	173175	39
RECLASS TO:			
NURSE CONSULTANT MILEAGE	$	2471	10
ADMIN. CONSULTANT MILEAGE		1410	17
RECLASS FROM: TRAVEL	$	-3881	24

SCHEDULE XVII - PAGE 1
RECONCILIATION OF INCOME

NET INCOME - LINE 43	$	315560
* MANAGEMENT FEE 7/31/99		-19106
* MANAGEMENT FEE 7/31/00		14012
RENTAL INCOME PASSED DIRECTLY TO SHAREHOLDERS		-20395
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS		-5060
TAXABLE INCOME	$	285011

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

PAGE 13 - SCHEDULE X - SECTION E
RECONCILIATION OF DEPRECIATION

LINE 49	$	19564
NURSING HOME MANAGERS ALLOCATION		1277
SCHEDULE V LINE 30 COLUMN 8	$	20841

PAGE 23 - SCHEDULE XX - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED BASED UPON TIME CARDS

PAGE 6 SCHEDULE VII B LINE 2
NURSING HOME MANAGERS COSTS

CENTRAL OFFICE COST ALLOCATION
HILLTOP
1999

	AUG 99	SEPT	OCT	NOV	DEC	JAN 00	FEB	MARCH	APRIL	MAY	JUNE	JULY	1999 TOTAL	LINE
SALARIES-ADMIN	$2,128	$2,125	$2,115	$2,138	$2,117	$2,058	$2,003	$1,926	$1,895	$1,938	$2,055	$2,071	$24,567	17
SALARIES-CLERIC	1,053	1,051	1,046	1,058	1,047	1,056	1,028	988	972	994	1,054	1,062	12,409	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	11
SALARIES-NURSE	69	69	69	70	69	0	0	0	0	0	0	0	346	10
ACCOUNTING	20	20	20	20	20	7	7	6	6	6	7	7	146	19
WORK COMP INS	4	4	4	4	4	11	11	10	10	10	11	11	93	22
SUPPLIES	47	47	47	47	47	100	98	94	92	94	100	101	914	21
TELEPHONE	41	41	40	41	40	48	46	45	44	45	48	48	526	21
EMPL BENEFITS	325	324	323	326	323	340	331	318	313	320	339	342	3,924	22
PAYROLL TAXES	246	246	244	247	245	253	246	237	233	238	253	255	2,943	22
TRAVEL	25	25	25	25	25	145	141	136	134	137	145	146	1,109	24
IN SERVICE	4	4	4	4	4	10	10	9	9	9	10	10	87	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	3	3	3	3	3	16	15	15	15	15	16	16	120	6
OWNERS COMP	247	246	245	248	245	241	235	226	222	227	241	243	2,866	17
INS-PROP,LIAB,WC	17	17	17	17	17	18	17	16	16	16	17	18	204	26
DEPRECIATION	104	103	103	104	103	112	109	105	103	106	112	113	1,277	30
RENT	239	239	238	240	238	248	241	232	228	234	248	250	2,875	34
MAINTENANCE	55	55	54	55	54	20	20	19	19	19	20	20	409	6
FEES & PUBLICAT	21	21	21	21	21	4	4	3	3	3	4	4	131	20
ADVERTISING	0	0	0	0	0	2	2	2	2	2	2	2	13	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$4,646	$4,640	$4,617	$4,669	$4,622	$4,688	$4,563	$4,386	$4,316	$4,414	$4,680	$4,718	$54,959	
FIXED ASSETS														
EQUIP - PRIOR	7,886	7,876	7,836	7,925	7,844	6,717	6,538	6,285	6,184	6,325	6,706	6,760	7,073	
EQUIP - CURR	1,010	1,009	1,004	1,015	1,005	1,359	1,606	2,894	2,847	2,912	3,088	3,112	1,905	
EQUIP - FULLY DEP	818	817	813	822	813	821	799	769	756	773	820	827	804	
BLDG - PRIOR	980	978	973	984	974	984	958	921	906	926	982	990	963	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MONTHLY COST ALLOCATIONS USED ON PAGE 26

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.57%	14.57%	16.98%	19.49%	11.65%	18.74%	100.00%
SALARIES-ADMIN	$2,713	$2,128	$2,481	$2,847	$1,702	$2,738	$14,609
SALARIES-CLERIC	1,342	1,053	1,227	1,408	842	1,354	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	88	69	81	93	55	89	476
ACCOUNTING	26	20	23	27	16	26	138
WORK COMP INS	5	4	4	5	3	5	25
SUPPLIES	60	47	55	63	38	61	324
TELEPHONE	52	41	47	54	33	52	279
EMPL BENEFITS	414	325	378	434	260	418	2,229
PAYROLL TAXES	314	246	287	329	197	316	1,689
TRAVEL	32	25	29	33	20	32	171
IN SERVICE	5	4	5	5	3	5	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	3	2	3	18
OWNERS COMP	315	247	288	330	197	317	1,694
INS-PROP,LIAB,WC	22	17	20	23	14	22	118
DEPRECIATION	132	104	121	139	83	133	711
RENT	305	239	279	320	191	308	1,642
MAINTENANCE	70	55	64	73	44	70	375
FEES & PUBLIC	27	21	25	28	17	27	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,925	$4,646	$5,417	$6,215	$3,716	$5,978	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,056	7,886	9,194	10,549	6,308	10,146	54,137
EQUIP - CURR	1,288	1,010	1,178	1,351	808	1,300	6,936
EQUIP - FULLY DEP	1,043	818	953	1,094	654	1,052	5,614
BLDG - PRIOR	1,249	980	1,142	1,310	784	1,260	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.68%	14.55%	17.11%	19.74%	12.69%	17.24%	100.00%
SALARIES-ADMIN	$2,728	$2,125	$2,499	$2,884	$1,853	$2,518	$14,609
SALARIES-CLERIC	1,350	1,051	1,237	1,427	917	1,246	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	89	69	81	94	60	82	476
ACCOUNTING	26	20	24	27	18	24	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	61	47	55	64	41	56	324
TELEPHONE	52	41	48	55	35	48	279
EMPL BENEFITS	416	324	381	440	283	384	2,229
PAYROLL TAXES	315	246	289	333	214	291	1,689
TRAVEL	32	25	29	34	22	29	171
IN SERVICE	5	4	5	5	3	5	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	3	2	3	18
OWNERS COMP	316	246	290	334	215	292	1,694
INS-PROP,LIAB,WC	22	17	20	23	15	20	118
DEPRECIATION	133	103	122	140	90	123	711
RENT	307	239	281	324	208	283	1,642
MAINTENANCE	70	55	64	74	48	65	375
FEES & PUBLIC	27	21	25	29	19	25	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,957	$4,640	$5,457	$6,297	$4,047	$5,498	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,111	7,876	9,262	10,687	6,868	9,332	54,137
EQUIP - CURR	1,295	1,009	1,187	1,369	880	1,196	6,936
EQUIP - FULLY DEP	1,049	817	960	1,108	712	968	5,614
BLDG - PRIOR	1,256	978	1,151	1,328	853	1,159	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.07%	14.47%	16.72%	20.30%	13.21%	16.22%	100.00%
SALARIES-ADMIN	$2,786	$2,115	$2,443	$2,965	$1,930	$2,370	$14,609
SALARIES-CLERIC	1,378	1,046	1,209	1,467	955	1,172	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	91	69	80	97	63	77	476
ACCOUNTING	26	20	23	28	18	22	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	62	47	54	66	43	53	324
TELEPHONE	53	40	47	57	37	45	279
EMPL BENEFITS	425	323	373	452	295	362	2,229
PAYROLL TAXES	322	244	282	343	223	274	1,689
TRAVEL	33	25	29	35	23	28	171
IN SERVICE	5	4	5	5	4	4	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	4	2	3	18
OWNERS COMP	323	245	283	344	224	275	1,694
INS-PROP,LIAB,WC	22	17	20	24	16	19	118
DEPRECIATION	136	103	119	144	94	115	711
RENT	313	238	275	333	217	266	1,642
MAINTENANCE	72	54	63	76	50	61	375
FEES & PUBLIC	28	21	24	30	19	24	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$6,082	$4,617	$5,334	$6,474	$4,215	$5,174	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,323	7,836	9,054	10,988	7,154	8,782	54,137
EQUIP - CURR	1,323	1,004	1,160	1,408	917	1,125	6,936
EQUIP - FULLY DEP	1,071	813	939	1,139	742	911	5,614
BLDG - PRIOR	1,282	973	1,125	1,365	889	1,091	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.10%	14.64%	16.53%	20.81%	12.45%	16.48%	100.00%
SALARIES-ADMIN	$2,790	$2,138	$2,414	$3,040	$1,819	$2,407	$14,609
SALARIES-CLERIC	1,380	1,058	1,194	1,504	900	1,191	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	91	70	79	99	59	78	476
ACCOUNTING	26	20	23	29	17	23	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	62	47	54	67	40	53	324
TELEPHONE	53	41	46	58	35	46	279
EMPL BENEFITS	426	326	368	464	278	367	2,229
PAYROLL TAXES	323	247	279	351	210	278	1,689
TRAVEL	33	25	28	36	21	28	171
IN SERVICE	5	4	4	6	3	4	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	4	2	3	18
OWNERS COMP	324	248	280	352	211	279	1,694
INS-PROP,LIAB,WC	22	17	19	25	15	19	118
DEPRECIATION	136	104	118	148	89	117	711
RENT	314	240	271	342	204	271	1,642
MAINTENANCE	72	55	62	78	47	62	375
FEES & PUBLIC	28	21	24	30	18	24	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$6,092	$4,669	$5,271	$6,637	$3,972	$5,256	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,340	7,925	8,947	11,264	6,741	8,920	54,137
EQUIP - CURR	1,325	1,015	1,146	1,443	864	1,143	6,936
EQUIP - FULLY DEP	1,072	822	928	1,168	699	925	5,614
BLDG - PRIOR	1,284	984	1,111	1,399	837	1,108	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.08%	14.49%	16.87%	20.33%	12.26%	16.97%	100.00%
SALARIES-ADMIN	$2,787	$2,117	$2,465	$2,969	$1,791	$2,479	$14,609
SALARIES-CLERIC	1,379	1,047	1,220	1,469	886	1,226	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	91	69	80	97	58	81	476
ACCOUNTING	26	20	23	28	17	23	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	62	47	55	66	40	55	324
TELEPHONE	53	40	47	57	34	47	279
EMPL BENEFITS	425	323	376	453	273	378	2,229
PAYROLL TAXES	322	245	285	343	207	287	1,689
TRAVEL	33	25	29	35	21	29	171
IN SERVICE	5	4	5	5	3	5	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	4	2	3	18
OWNERS COMP	323	245	286	344	208	287	1,694
INS-PROP,LIAB,WC	22	17	20	24	14	20	118
DEPRECIATION	136	103	120	145	87	121	711
RENT	313	238	277	334	201	279	1,642
MAINTENANCE	72	54	63	76	46	64	375
FEES & PUBLIC	28	21	25	30	18	25	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$6,086	$4,622	$5,383	$6,484	$3,911	$5,413	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,329	7,844	9,135	11,004	6,638	9,187	54,137
EQUIP - CURR	1,323	1,005	1,170	1,410	850	1,177	6,936
EQUIP - FULLY DEP	1,071	813	947	1,141	688	953	5,614
BLDG - PRIOR	1,283	974	1,135	1,367	825	1,141	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
SALARIES-ADMIN	$2,762	$2,058	$2,461	$2,856	$1,668	$2,261	$14,066
SALARIES-CLERIC	1,417	1,056	1,262	1,465	856	1,160	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	7	8	9	5	7	$46
WORK COMP INS	15	11	13	15	9	12	$75
SUPPLIES	134	100	120	139	81	110	$685
TELEPHONE	64	48	57	66	39	52	$326
EMPL BENEFITS	456	340	407	472	276	374	$2,324
PAYROLL TAXES	340	253	303	351	205	278	$1,730
TRAVEL	195	145	174	202	118	160	$993
IN SERVICE	13	10	12	14	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	21	16	19	22	13	17	$108
OWNERS COMP	324	241	289	335	196	265	$1,650
INS-PROP,LIAB,WC	24	18	21	24	14	19	$120
DEPRECIATION	150	112	134	156	91	123	$766
RENT	333	248	297	344	201	273	$1,696
MAINTENANCE	27	20	24	28	16	22	$137
FEES & PUBLIC	5	4	4	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$6,291	$4,688	$5,606	$6,507	$3,801	$5,150	$32,044
FIXED ASSETS							
EQUIP - PRIOR	9,014	6,717	8,033	9,323	5,446	7,379	45,912
EQUIP - CURR	1,824	1,359	1,625	1,886	1,102	1,493	9,290
EQUIP - FULLY DEP	1,102	821	982	1,140	666	902	5,614
BLDG - PRIOR	1,320	984	1,177	1,366	798	1,081	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
SALARIES-ADMIN	$2,620	$2,003	$2,576	$2,784	$1,713	$2,371	$14,066
SALARIES-CLERIC	1,344	1,028	1,321	1,428	879	1,216	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	7	8	9	6	8	$46
WORK COMP INS	14	11	14	15	9	13	$75
SUPPLIES	128	98	125	136	83	115	$685
TELEPHONE	61	46	60	65	40	55	$326
EMPL BENEFITS	433	331	426	460	283	392	$2,324
PAYROLL TAXES	322	246	317	342	211	292	$1,730
TRAVEL	185	141	182	196	121	167	$993
IN SERVICE	13	10	12	13	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	21	13	18	$108
OWNERS COMP	307	235	302	327	201	278	$1,650
INS-PROP,LIAB,WC	22	17	22	24	15	20	$120
DEPRECIATION	143	109	140	152	93	129	$766
RENT	316	241	311	336	207	286	$1,696
MAINTENANCE	26	20	25	27	17	23	$137
FEES & PUBLIC	5	4	5	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,968	$4,563	$5,867	$6,341	$3,903	$5,402	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,550	6,538	8,407	9,085	5,592	7,740	45,912
EQUIP - CURR	2,100	1,606	2,065	2,231	1,373	1,901	11,276
EQUIP - FULLY DEP	1,046	799	1,028	1,111	684	946	5,614
BLDG - PRIOR	1,252	958	1,231	1,331	819	1,134	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
SALARIES-ADMIN	$2,588	$1,926	$2,643	$2,724	$1,704	$2,482	$14,066
SALARIES-CLERIC	1,328	988	1,356	1,397	874	1,273	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	8	6	9	9	6	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	126	94	129	133	83	121	$685
TELEPHONE	60	45	61	63	39	58	$326
EMPL BENEFITS	428	318	437	450	282	410	$2,324
PAYROLL TAXES	318	237	325	335	210	305	$1,730
TRAVEL	183	136	187	192	120	175	$993
IN SERVICE	12	9	13	13	8	12	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	21	13	19	$108
OWNERS COMP	304	226	310	320	200	291	$1,650
INS-PROP,LIAB,WC	22	16	22	23	15	21	$120
DEPRECIATION	141	105	144	148	93	135	$766
RENT	312	232	319	328	205	299	$1,696
MAINTENANCE	25	19	26	27	17	24	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	2	2	3	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,896	$4,386	$6,022	$6,205	$3,882	$5,653	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,447	6,285	8,628	8,890	5,562	8,100	45,912
EQUIP - CURR	3,889	2,894	3,972	4,093	2,561	3,729	21,138
EQUIP - FULLY DEP	1,033	769	1,055	1,087	680	990	5,614
BLDG - PRIOR	1,237	921	1,264	1,302	815	1,186	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
SALARIES-ADMIN	$2,577	$1,895	$2,706	$2,748	$1,696	$2,443	$14,066
SALARIES-CLERIC	1,322	972	1,388	1,410	870	1,253	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	8	6	9	9	6	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	125	92	132	134	83	119	$685
TELEPHONE	60	44	63	64	39	57	$326
EMPL BENEFITS	426	313	447	454	280	404	$2,324
PAYROLL TAXES	317	233	333	338	209	300	$1,730
TRAVEL	182	134	191	194	120	172	$993
IN SERVICE	12	9	13	13	8	12	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	21	21	13	19	$108
OWNERS COMP	302	222	317	322	199	287	$1,650
INS-PROP,LIAB,WC	22	16	23	23	14	21	$120
DEPRECIATION	140	103	147	150	92	133	$766
RENT	311	228	326	331	204	295	$1,696
MAINTENANCE	25	19	26	27	17	24	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	2	2	3	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,871	$4,316	$6,165	$6,261	$3,864	$5,566	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,412	6,184	8,834	8,971	5,536	7,975	45,912
EQUIP - CURR	3,873	2,847	4,067	4,130	2,549	3,672	21,138
EQUIP - FULLY DEP	1,029	756	1,080	1,097	677	975	5,614
BLDG - PRIOR	1,232	906	1,294	1,314	811	1,168	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
SALARIES-ADMIN	$2,637	$1,938	$2,581	$2,876	$1,659	$2,376	$14,066
SALARIES-CLERIC	1,353	994	1,324	1,475	851	1,219	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	6	8	9	5	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	128	94	126	140	81	116	$685
TELEPHONE	61	45	60	67	38	55	$326
EMPL BENEFITS	436	320	426	475	274	393	$2,324
PAYROLL TAXES	324	238	317	354	204	292	$1,730
TRAVEL	186	137	182	203	117	168	$993
IN SERVICE	13	9	12	14	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	22	13	18	$108
OWNERS COMP	309	227	303	337	195	279	$1,650
INS-PROP,LIAB,WC	22	16	22	24	14	20	$120
DEPRECIATION	144	106	141	157	90	129	$766
RENT	318	234	311	347	200	286	$1,696
MAINTENANCE	26	19	25	28	16	23	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$6,007	$4,414	$5,879	$6,552	$3,780	$5,412	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,606	6,325	8,423	9,388	5,416	7,754	45,912
EQUIP - CURR	3,962	2,912	3,878	4,322	2,494	3,570	21,138
EQUIP - FULLY DEP	1,052	773	1,030	1,148	662	948	5,614
BLDG - PRIOR	1,261	926	1,234	1,375	793	1,136	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
SALARIES-ADMIN	$2,626	$2,055	$2,583	$2,846	$1,694	$2,264	$14,066
SALARIES-CLERIC	1,347	1,054	1,325	1,460	869	1,161	7,216
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	8	9	6	7	46
WORK COMP INS	14	11	14	15	9	12	75
SUPPLIES	128	100	126	139	82	110	685
TELEPHONE	61	48	60	66	39	52	326
EMPL BENEFITS	434	339	427	470	280	374	2,324
PAYROLL TAXES	323	253	318	350	208	278	1,730
TRAVEL	185	145	182	201	120	160	993
IN SERVICE	13	10	12	14	8	11	68
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	20	16	20	22	13	17	108
OWNERS COMP	308	241	303	334	199	266	1,650
INS-PROP,LIAB,WC	22	17	22	24	14	19	120
DEPRECIATION	143	112	141	155	92	123	766
RENT	317	248	311	343	204	273	1,696
MAINTENANCE	26	20	25	28	17	22	137
FEES & PUBLIC	5	4	5	5	3	4	25
ADVERTISING	3	2	2	3	2	2	13
	0	0	0	0	0	0	0
TOTAL	$5,982	$4,680	$5,884	$6,482	$3,858	$5,157	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,571	6,706	8,431	9,288	5,528	7,388	45,912
EQUIP - CURR	3,946	3,088	3,882	4,276	2,545	3,402	21,138
EQUIP - FULLY DEP	1,048	820	1,031	1,136	676	903	5,614
BLDG - PRIOR	1,255	982	1,235	1,360	810	1,082	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

COST ALLOCATION
JULY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%
SALARIES-ADMIN	$2,632	$2,071	$2,722	$2,838	$1,657	$2,146	$14,066
SALARIES-CLERIC	1,350	1,062	1,396	1,456	850	1,101	7,216
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	5	7	46
WORK COMP INS	14	11	15	15	9	11	75
SUPPLIES	128	101	133	138	81	104	685
TELEPHONE	61	48	63	66	38	50	326
EMPL BENEFITS	435	342	450	469	274	355	2,324
PAYROLL TAXES	324	255	335	349	204	264	1,730
TRAVEL	186	146	192	200	117	151	993
IN SERVICE	13	10	13	14	8	10	68
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	20	16	21	22	13	16	108
OWNERS COMP	309	243	319	333	194	252	1,650
INS-PROP,LIAB,WC	22	18	23	24	14	18	120
DEPRECIATION	143	113	148	155	90	117	766
RENT	317	250	328	342	200	259	1,696
MAINTENANCE	26	20	27	28	16	21	137
FEES & PUBLIC	5	4	5	5	3	4	25
ADVERTISING	3	2	3	3	2	2	13
	0	0	0	0	0	0	0
TOTAL	$5,996	$4,718	$6,201	$6,465	$3,776	$4,889	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,591	6,760	8,884	9,262	5,410	7,004	45,912
EQUIP - CURR	3,955	3,112	4,090	4,264	2,491	3,225	21,138
EQUIP - FULLY DEP	1,051	827	1,086	1,133	662	856	5,614
BLDG - PRIOR	1,258	990	1,301	1,357	792	1,026	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES USED ON PAGE 27

OCCUPIED DAYS 1999	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,678	2,190	2,298	2,108	599	1,557	2,603	14,033
FEBRUARY	2,471	1,935	2,036	1,894	594	1,322	2,314	12,566
MARCH	2,681	2,164	2,223	2,021	633	1,397	2,364	13,483
APRIL	2,482	1,983	2,120	1,906	596	1,351	2,421	12,859
MAY	2,586	1,928	2,189	1,871	615	1,472	2,379	13,040
JUNE	2,349	1,864	2,168	1,899	583	1,418	2,256	12,537
JULY	2,331	1,911	2,239	1,894	601	1,432	2,373	12,781
AUGUST	2,345	1,839	2,144	1,848	612	1,471	2,366	12,625
SEPTEM	2,298	1,790	2,105	1,786	643	1,561	2,121	12,304
OCTOBER	2,391	1,815	2,097	1,820	725	1,657	2,034	12,539
NOVEMBEF	2,316	1,775	2,004	1,831	692	1,510	1,998	12,126
DECEMBEF	2,415	1,834	2,136	1,881	692	1,552	2,148	12,658
TOTAL	29,343	23,028	25,759	22,759	7,585	17,700	27,377	153,551
								153,551

OCCUPIED DAYS 2000	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,453	1,828	2,186	1,874	663	1,482	2,008	12,494
FEBRUARY	2,205	1,686	2,168	1,746	597	1,442	1,996	11,840
MARCH	2,383	1,773	2,434	1,904	604	1,569	2,285	12,952
APRIL	2,273	1,671	2,387	1,783	641	1,496	2,155	12,406
MAY	2,301	1,691	2,252	1,910	600	1,448	2,073	12,275
JUNE	2,211	1,730	2,175	1,793	603	1,426	1,906	11,844
JULY	2,317	1,823	2,396	1,846	652	1,459	1,889	12,382
AUGUST								0
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	16,143	12,202	15,998	12,856	4,360	10,322	14,312	86,193
								86,193

ALLOCATION PERCENTAGE 1999	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	19.08%	15.61%	16.38%	19.29%	11.10%	18.55%	100.00%
FEBRUARY	19.66%	15.40%	16.20%	19.80%	10.52%	18.41%	100.00%
MARCH	19.88%	16.05%	16.49%	19.68%	10.36%	17.53%	100.00%
APRIL	19.30%	15.42%	16.49%	19.46%	10.51%	18.83%	100.00%
MAY	19.83%	14.79%	16.79%	19.06%	11.29%	18.24%	100.00%
JUNE	18.74%	14.87%	17.29%	19.80%	11.31%	17.99%	100.00%
JULY	18.24%	14.95%	17.52%	19.52%	11.20%	18.57%	100.00%
AUGUST	18.57%	14.57%	16.98%	19.49%	11.65%	18.74%	100.00%
SEPTEMBER	18.68%	14.55%	17.11%	19.74%	12.69%	17.24%	100.00%
OCTOBER	19.07%	14.47%	16.72%	20.30%	13.21%	16.22%	100.00%
NOVEMBER	19.10%	14.64%	16.53%	20.81%	12.45%	16.48%	100.00%
DECEMBER	19.08%	14.49%	16.87%	20.33%	12.26%	16.97%	100.00%

ALLOCATION PERCENTAGE 2000	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
FEBRUARY	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
MARCH	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
APRIL	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
MAY	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
JUNE	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
JULY	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%